DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03 -- 010

2. STATE: MAINE

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Maine (03-010)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4 PROPOSED EFFECTIVE DATE(S)
JULY 1, 2003
Approved: 12/19/03
Effective: 07/01/03

5. TYPE OF PLAN MATERIAL *(CHECK ONE)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
SECTION 1932(A)(1)(A)

7. FEDERAL BUDGET IMPACT:
a. FFY NA $ 0
b. FFY $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
3.1.F UPDATE ENTIRE SECTION

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
3.1.F UPDATE ENTIRE SECTION

10. SUBJECT OF AMENDMENT:
PRIMARY CARE CASE MANAGEMENT-AMENDMENT REFLECTS REMOVAL OF OUTDATED LANGUAGE REGARDING MCO PARTICIPATION AND INCLUDES PROGRAMMATIC UPDATES TO PRIMARY CARE CASE MANAGEMENT .

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
COMMISSIONER, DEPT. OF HUMAN SERVICES

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Peter E. Walsh

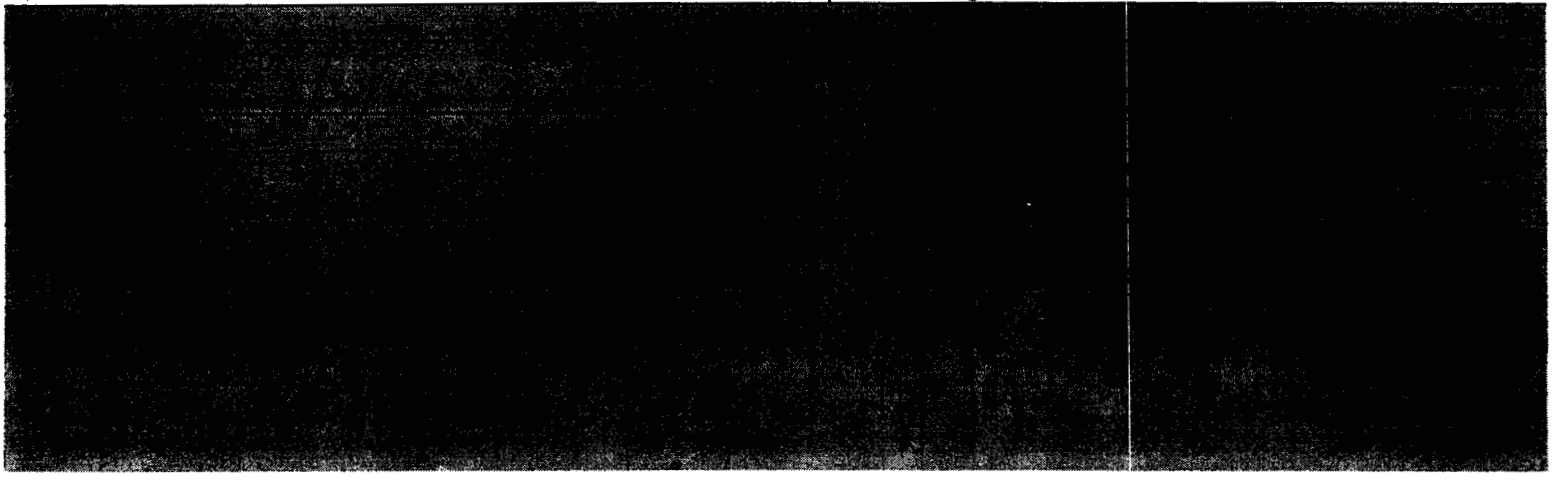
13. TYPED NAME:
PETER E. WALSH

14. TITLE:
ACTING Commissioner, Maine Department of Human Services

15. DATE SUBMITTED: SEPTEMBER 30, 2003

16. RETURN TO:

CHRISTINE ZUKAS-LESSARD, ACTING DIRECTOR
Bureau of Medical Services
#11 State House Station
442 CIVIC CENTER DRIVE
Augusta, ME 04333-0011



FORM HCFA-179 (07-92)

Instructions on Back

ATTACHMENT 3.1-F

State/Territory: Maine

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

PROGRAM NAME: MaineCare - Primary Care Case Management

I. CITATION: SECTION 1932 (A)(1)(A) OF THE SOCIAL SECURITY ACT

The State of Maine enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (i.e. PCCMs) in the absence of section 1115 or section 1915 (b) waiver authority. This authority is granted under section 1932 (a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used for Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP) programs.

II. GENERAL DESCRIPTION OF THE PROGRAM AND PUBLIC PROCESS

1. Describe the type of entities the state will contract with, and indicate if the contract is a comprehensive risk contract. Include the payment method to be utilized (i.e. fee for service, capitation, case management fee, bonus/incentive and/or supplemental payments).

   The State of Maine elects to use the state option under section 1932 to require certain MaineCare members (described in Section IV(A)) to enroll in primary care case management on a mandatory basis. Primary care case management is currently operational in all 16 counties of the State. Those MaineCare members not required to enroll, or otherwise exempted from participation in primary care case management, receive benefits through the fee-for-service system. A Health Benefits Advisor is currently contracted with the State to enroll MaineCare members into primary care case management and provide member service functions for PCCM members.

   MaineCare members enrolled in primary care case management are required to select a Primary Care Provider (PCP) who is responsible for providing or authorizing certain services. (Excluded services are described in Section VII.) In addition to fee-for-service payments, Primary Care Providers enrolled in primary care case management are paid a monthly management fee for each managed care member assigned to their panel (regardless of whether the member used services during the month).

   The following provider types may serve as Primary Care Providers:

   General practitioner, family practitioner, internist, obstetrician/gynecologist or other physician group specialty as approved by the State in either a solo or group practice; a rural

health clinic, federally qualified health center, ambulatory care clinic or hospital based/affiliated outpatient clinic that employs at least one full time equivalent PCP engaged in delivering primary care; a nurse practitioner, physician assistant or a resident in a pediatric, family practice, internal medicine or obstetric/gynecological training program.

2. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan has been implemented.

   Public input has been elicited on an ongoing basis from point of design to current implementation. Primary care case management operational guidelines are set forth, and open for public comment, through rule-making under the Administrative Procedure Act. Current operational guidelines can be found in Chapter VI, Section 1 of the MaineCare Benefits Manual, published on the Secretary of State's web site under the heading of the Department of Human Services.

   In addition, input is elicited on an ongoing process through two venues: the Outreach and Education Task Force and the MaineCare Managed Care Physician Advisory Committee. The Outreach and Education Task Force meets every other month and is comprised of representatives of the Bureau of Medical Services, the Health Benefits Advisor and consumer advocacy organizations within the State. The focus of the Task Force is to share and exchange information regarding primary care case management operational issues, to address areas of concern and to be kept apprised of outreach activities being conducted by advocacy organizations within the State related to primary care case management.

   The Physician Advisory Committee meets quarterly and is comprised of a representative group of MaineCare physicians who also serve as Primary Care Providers under primary care case management. In addition to being representative of the practice groups participating in primary care case management, two of the participants also represent two of the major medical associations within the State: the Maine Medical Association and the Maine Osteopathic Association. The purpose of the Committee is to discuss/address clinical issues and policies and to elicit feedback from physicians participating in primary care case management.

3. Affirm if the state plan program will implement mandatory enrollment into managed care on a statewide basis. If not, identify the county/areas where mandatory enrollment will be implemented.

   Mandatory enrollment into primary care case management has been implemented in all 16 counties in the State.

III. ASSURANCES AND COMPLIANCE WITH THE STATUTE AND REGULATIONS

The state assures all the applicable requirements of the statute and regulations are met:

- Section 1903 (m) of the Act, for MCOs and MCO contracts.

The State has no contracts with MCOs.

- Section 1905 (t) of the Act for PCCMs and PCCM contracts.

  The State asserts compliance with provisions of Section 1905 (t) of the Act for PCCMs and PCCM contracts.

- Section 1932 (including Section (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities.

  The State asserts compliance with applicable requirements of Section 1932 regarding operation of its primary care case management benefit.

- 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in Section 1905 (a)(4)(C)

  The State asserts compliance with 42 CFR 431.51 regarding freedom of choice for family planning services/supplies under the primary care case management benefit.

- 42 CFR 438 for MCOs and PCCMs.

  The State asserts compliance with applicable provisions of 42 CFR 438 regarding primary care case management.

- 42 CFR 438.6 (c) of the regulations for payments under any risk contracts.

  N/A

- 42 CFR 434 of the regulations that are applicable to HIOs.

  N/A

- 42 CFR 447.362 for payments under any nonrisk contracts.

  The State asserts that the primary care case management benefit will operate within the fee-for-service upper payment limit.

- 45 CFR part 74 for procurement of contracts.

  The State asserts compliance with applicable provisions of 45 CFR 74 regarding procurement of contracts.

ATTACHMENT 3.1-F

IV. ELIGIBLE GROUPS

A. LIST ALL ELIGIBLE GROUPS THAT WILL BE ENROLLED ON A MANDATORY BASIS

A MaineCare member must participate in primary care case management if he/she is in one of the following categories:

a. Receiving Temporary Assistance for Needy Families (TANF) - Adults and Children;

b. Children under the age of twenty-one (21); parents of children under age eighteen (18) who receive MaineCare; pregnant women; and those members eligible for transitional MaineCare;

c. Women who have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Title XV Program and are found to need treatment for breast or cervical cancer, including pre-cancerous conditions, as defined in Section 2150.03 of the MaineCare Eligibility Manual;

d. Adults, ages 21 through 64, who do not have children or do not have children under age 18 living with them and are at or below 100% of the Federal Poverty Level;

e. Individuals who fall within the eligibility categories noted in a., b., c., and d. above who are:

   i. Alaskan Natives or Native Americans who are members of Federally recognized tribes;

   ii. Foster Care Children not placed out of State;

   iii. Children with Adoption Assistance; and

   iv. Individuals under the age of 19 with special health care needs.

Those eligibility categories noted in (e) above are contingent upon the approval of a waiver by the Centers for Medicare and Medicaid Services.

B. MANDATORY EXEMPT GROUPS

The state enrolls (as indicated by a check mark) the following exempt populations on a voluntary basis:

1. Recipients who are eligible for Medicare

_____ The state will allow these individuals to voluntarily enroll in the managed care program.

2. Indians who are members of Federally recognized tribes except when the MCO or PCCM is the Indian Health Service; or an Indian Health program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service.

   *X___ The state will allow these individuals to voluntarily enroll in the managed care program.
   *Native Americans, while not automatically exempted from participation, may choose to participate on a voluntary basis. All Indian Health Service facilities serve as PCPs under the program and no claims are denied for Native Americans who access MaineCare services without approval of a PCP.

3. Children under the age of 19 years, who are eligible for Supplemental Security Income under Title XVI.

   _____ The state will allow these individuals to voluntarily enroll in the managed care program.

4. Children under the age of 19 years who are eligible under section 1902(e)(3) of the Act.

   _____ The state will allow these individuals to voluntarily enroll in the managed care program.

5. Children under the age of 19 years who are foster care or other out-of-the-home placement.

   _____ The state will allow these individuals to voluntarily enroll in the managed care program.

6. Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E

   _____ The state will allow these individuals to voluntarily enroll in the managed care program.

7. Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs.

   _____ The state will allow these individuals to voluntarily enroll in the managed care program.

~~401~~ 410 544 2864

C. LIST ALL OTHER GROUPS THAT ARE PERMITTED TO ENROLL ON A VOLUNTARY BASIS

Certain MaineCare members may request an exemption from participation in primary care case management on the basis of individual conditions. Conditions supporting an

exemption are listed below. Those MaineCare members identified as exempt, but otherwise eligible for participation in primary care case management, may voluntarily choose to participate in primary care case management.

An individual is eligible to request an exemption if she/he:

a. Administrative Exemptions

i. has to travel more than thirty (30) minutes to a participating PCP (if not in an established relationship with a participating PCP);

ii. is homeless;

iii. is a migrant or a family member accompanying a migrant;

iv. has specific language barriers or cultural needs which may not be addressed by an available PCP. Culturally appropriate care is care that is provided with sensitivity, understanding and respect for the member's culture. Each of these cases will be reviewed by the Bureau of Medical Services for cultural sensitivity/medical necessity for exemption;

v. is required to follow member restriction provisions;

vi. is residing out of State;

vii. does not have an updated address;

viii. is residing in a jail or State or private mental institution; or

ix. may qualify for a temporary exemption including:

(1.) Non-English speaking members. Members who are identified by the Bureau of Medical Services as using English as a second language will be granted a temporary exemption from participation in primary care case management. A temporary exemption will be granted in the event the Health Benefits Advisor is unsuccessful in contacting these individuals during the first twenty-eight (28) calendar days of eligibility. The exemption will be granted until such time as contact can be made with the individual to elicit a voluntary choice of PCPs. Duration of the exemption may not exceed sixty (60) calendar days.

(2.) A member who has a PCP pending. Temporary exemption from participation in primary care case management will be granted to an individual whose provider is not currently enrolled in primary care case management, but the provider is eligible and has expressed a willingness to enroll. Duration of the exemption may not exceed forty-five (45) calendar days. Additionally, the exemption will expire and

the individual will be required to select another PCP if, for any reason, the individual's provider does not enroll in primary care case management.

b. Clinical Exemptions

i. has a terminal illness and has an established relationship with a qualified health care provider who is not a qualified MaineCare primary care case management PCP. Each of these cases will be reviewed by the MaineCare Medical Director for medical necessity for exemption;

ii. has a chronic and debilitating condition which requires managed services from a qualified primary care health provider who is not a MaineCare primary care case management PCP. Each of these cases will be reviewed by the MaineCare Medical Director for medical necessity for exemption.

iii. is an inpatient of a hospital on the date of enrollment. Such individuals will have effective enrollment periods after hospital discharge; or

iv. is receiving hospice care.

D. IDENTIFICATION OF EXEMPT POPULATIONS

1. How does the state define children who receive services funded under section 501 (a)(1)(D) of Title V?

The State identifies this population by aid category.

2. Is the state's definition of these children in terms of program participation or special health care needs?

The State's definition is based on special health care needs.

3. Does the scope of these Title V services include services received through a family-centered, community-based, coordinated care system?

The scope of services excludes those services received through family-centered, community-based, coordinated care systems.

4. How does the state identify the following groups of children who are exempt from mandatory enrollment:

The State identifies populations noted below by aid category.

a. Children under 19 years of age who are eligible for SSI under Title XVI;

b. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

c. Children under 19 years of age who are receiving foster care or adoption assistance under title IV-E of the Act.

5. What is the state's process for allowing children to request an exemption based on the special needs criteria as defined in the state plan if they are not initially identified as exempt from mandatory enrollment?

Please see Section IV(C).

6. How does the state identify the following groups who are exempt from mandatory enrollment into managed care:

a. Individuals who are also eligible for Medicare.

The State receives enrollment information from Medicare in order to identify this population for exemption.

b. Indians who are members of a Federally recognized tribes, except when the MCO or PCCM is the Indian Health Service; or an Indian Health program or Urban Indian program is operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service.

Please see Section IV(B)(2).

E. LIST OTHER POPULATIONS (NOT PREVIOUSLY MENTIONED) WHO ARE EXEMPT FROM MANDATORY ENROLLMENT.

Other population groups (not previously mentioned) who are excluded from mandatory enrollment in primary care case management include the following:

1. Individuals with other forms of comprehensive health insurance;

2. Individuals with an eligibility period of less than three (3) months, or one that is only retroactive;

3. Individuals eligible for SSI;

4. Individuals residing in a nursing facility or intermediate care facility for the mentally retarded (ICF-MR); and

5. Members receiving Home and Community Benefits.

V. ENROLLMENT PROCESS

A. DEFINITIONS

An **existing provider-recipient relationship** is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

A provider is considered to have **"traditionally served"** Medicaid recipients if it has experience in serving the Medicaid population.

B. STATE PROCESS FOR ENROLLMENT BY DEFAULT

1. Describe how the state's default enrollment process will preserve:

The following is a description of the assignment process:

When a member is unable or unwilling to select a MaineCare primary care case management PCP within twenty-eight (28) calendar days of the date in which the enrollment packet was mailed, the member will be assigned to a PCP who has an opening on his/her panel. Members will be assigned to a PCP based on age and gender-appropriateness and in accordance with the travel time standard. To the extent possible, members will be assigned in consideration of the following: (a) individuals (including individuals within family units) will be assigned to their existing participating PCPs; (b) family units will be assigned to the same participating PCP or to a PCP the enrolled member has selected, if that PCP is appropriate based on age and gender parameters.

a. the existing provider-recipient relationship;

   As noted above, any member unable or unwilling to select a PCP is assigned, to the extent possible, to their existing (participating) PCP.

b. the relationship with providers that have traditionally served Medicaid recipients;

   All PCPs participating in PCCM are also MaineCare providers providing services to MaineCare members who receive benefits under the fee-for-service system.

c. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702 (a)(4)), and

   Where maintaining existing provider-member relationship is not possible, members are enrolled in consideration of equitable distribution of members among qualified, available PCPs.

d. disenrollment for cause in accordance with 42 CFR 438.56 (d)(2).